

October 11, 2006

VHA OUTPATIENT SCHEDULING PROCESSES AND PROCEDURES

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy for implementing processes and procedures for the scheduling of outpatient clinic appointments and for ensuring the competency of staff directly or indirectly involved in any or all components of the scheduling process.

2. BACKGROUND

a. The assurance of timely access to VHA care requires consistent and efficient use of Veterans Health Information Systems and Technology Architecture (VistA) scheduling options in the scheduling of outpatient clinic appointments and in the utilization of the Electronic Wait List (EWL) when an appointment cannot be scheduled within VHA timelines.

b. VHA is mandated to provide priority care for non-emergent outpatient medical services for any condition of a service-connected (SC) veteran rated 50 percent or greater or for a veteran's SC disability. VHA's goal is to have no waits or delays and to create appointments that meet the patient's needs in order to provide quality care when veterans want and need it. In every instance, VHA must provide clinically-appropriate care to every enrolled veteran. Through the use of performance measures and monitors, VHA monitors wait times within primary care and certain outpatient specialty clinics. VHA also surveys new and established patients to determine if they received an appointment when they wanted one. Acceptable levels of performance are established each year in VHA's performance plan. ***NOTE:** Medical care for emergent or urgent cases takes precedence over a priority of service connection.*

c. Public Law (Pub. L.) 104-262, the Veterans Health Care Eligibility Reform Act of 1996, mandated VHA establish and implement a national enrollment system to manage the delivery of health care services to veterans. Enactment of this legislation has generated a significant increase in VHA enrollees and patient users.

d. Sites have employed a variety of methods to manage patient demand when the demand exceeds their current capacity to provide care. VHA is striving to use the principles of Advanced Clinical Access (ACA) in all of its clinic settings as a method to assist with balancing supply and demand.

e. The assurance of tracking and assessing the utilization and resource needs for specialty care requires the use of VistA's electronic consult request package. With the implementation of VHA's electronic medical record, there is no place in the record to store non-electronic consult requests short of scanning them in. In addition, if an electronically-requested consult is not completed in the consult package (i.e., on the Consult tab within Computerized Patient Record System (CPRS)) by the consulting provider, the consult remains in the record as a pending resolution. Inability to track consult completion creates a potential patient safety hazard, particularly for patients for whom the consult is critical.

THIS VHA DIRECTIVE EXPIRES OCTOBER 31, 2011

October 11, 2006

f. Definitions

(1) **Advanced Clinical Access (ACA).** ACA is a patient-centered, scientifically-based set of redesign principles and tools that enable staff to examine their health care processes and redesign them. The ACA principles are extraordinarily powerful and result not only in improved access, but also in improved patient, staff, and provider satisfaction; improved quality; improved efficiency; and decreased cost (see Att. A). **NOTE:** *Information of ACA principles and best practices are available at <http://aca.vssc.med.va.gov>.*

(2) **Closed Primary Care (PC) Panel.** A Closed PC Panel is a panel that has reached its maximum capacity threshold as defined by facility or Veterans Integrated Services Network (VISN) policy. Guidance on determination of panel size is provided with the aim of establishing a VHA primary care system that balances productivity with quality, access, and patient service. For sites with a patient population reflecting the norms for disease severity and reliance on VHA, and who have current norms of 2.17 support staff per 1.0 FTE provider and 3.0 clinic rooms per 1.0 Full-time Equivalent (FTE) provider, an expected panel would be 1,200 patients for a full-time, established primary care physician. After adjustment for the factors identified, expected panels for VHA primary care providers will largely fall in the range of 1,000 to 1,500. Non-physician providers (Nurse Practitioner (NP) or Physician Assistant (PA)) are expected to carry panels 75 percent the size of 1.0 FTE physician providers. However, ratios of support staff and space need to be the same for 1.0 FTE non-physician providers as for 1.0 FTE physician providers.

(3) **Dental Care Eligibility.** Eligibility for dental care is specified by legislative authority and is defined in VHA Directive 1130.1.

(4) **Desired Date.** The desired appointment date is the earliest date on which the patient or clinician specifies the patient needs to be seen. This desired date may be the date the request is made by the patient, or the date a request is made by a clinician. When available, the desired date may be a specific date to be seen submitted by the patient or by the requesting provider. In some cases, the desired date may need to be modified after an initial appropriate clinic review. For example: a patient may request to be seen by a specialist, but a clinician reviewing the request may determine that before being seen in specialty care, the patient needs to be evaluated in primary care.

(5) **Emergent Care.** Emergent care is care for a condition for which immediate treatment is required to prevent the loss of life or limb, or is required to prevent the progression of a disease process that could lead to loss of life.

(6) **New Enrollee.** A new enrollee is a previously non-enrolled veteran who applies for Department of Veterans Affairs (VA) health care benefits and enrollment by submitting VA Form 10-10EZ, Application for Health Benefits, and who is determined eligible, is then enrolled by VA, and then seeks care from VA for the first time.

(7) **Open Primary Care Panel.** An Open Primary Care Panel is a panel that has not reached its maximum capacity threshold as defined by facility or VISN policy.

(8) **Panel.** A panel is a discrete population of patients assigned within the VHA Primary Care Management Module (PCMM) software to a single Primary Care Provider (PCP) for their health care management.

(9) **Preferred Facility.** The preferred facility is the VA facility in which the veteran expresses preference for care and in which the major portion of the veteran's primary care is provided.

(10) **Preferred Location.** The preferred location is a campus or Community-based Outpatient Clinic (CBOC) within a single facility at which the patient has indicated the patient would prefer to receive either primary or specialty care.

(11) **Primary Care Provider (PCP)**

(a) A PCP is a single provider, supported by a team, who is assigned responsibility for managing the health care of a discrete population (panel) of patients. NPs and PAs may serve as PCPs when their scope-of-practice or locally established privileges encompass the skills and responsibilities required to provide primary care for these patients.

(b) VHA policy defining how patients are assigned to primary care providers states that, in general, patients should have only one PCP within the VA health care system; however:

1. An exception may occur for a veteran with spinal cord injuries or disorders (SCI&D) receiving highly-coordinated dual care, as delivered within the VHA Spinal Cord Injury (SCI) "Hub and Spokes" continuum of care. The veteran may be assigned to a PC team at both the SCI referral center (Hub), and at their own local facility (Spoke).

2. An exception may occur for a patient who splits the principal residence between two locations and spends significant amounts of time at each. If such a patient has complicated care requiring close on-going care management, it may be appropriate to have an identified PCP at VHA health care facilities in each of the geographically-separated residences; however, this practice is to be minimized. Patients who clearly have a single principal residence and whose health care needs do not require complicated care management are not to be assigned a second PCP. Patients who seek episodic care while traveling are not to be assigned a second PCP when they are seen at a VHA facility other than at their preferred site.

(12) **Service Connection.** Service connection or "service connected" (SC) means that with respect to a condition or disability, VA has determined that the condition or disability was incurred in, or has been aggravated by, military service.

(13) **Urgent Care.** Urgent care is care for a condition for which there is a pressing need for treatment to prevent deterioration of the condition, or the impairment of the possibility for recovery. For example, urgent care includes the follow-up appointment for a patient discharged from a VA hospital, if the discharging physician directs that the patient must return on a specified day for the appointment.

VHA DIRECTIVE 2006-055

October 11, 2006

g. **Business Rules.** The Business Rules are outlined in Attachments A through G.

(1) Attachment A, General Business Rules.

(2) Attachment B, Competency of Staff.

(3) Attachment C, Enrollment and Registration.

(4) Attachment D, Scheduling.

(5) Attachment E, Consult Management.

(6) Attachment F, Electronic Wait List (EWL).

(7) Attachment G, No Shows, Patient Cancellations, and Clinic Cancellations.

3. POLICY: It is VHA policy that the business rules (i.e., mandated policy) outlined in Attachments A-G must be instituted and maintained in the management of enrollment, registration, scheduling, primary care team and/or provider assignment, consult management, and EWL processes.

4. ACTION

a. **Veterans Integrated Service Network (VISN) Director.** The VISN Director, or designee, is responsible for:

(1) Ensuring VISN-wide education of staff involved in clinical and administrative services on the principles and strategies of ACA.

(2) The oversight of scheduling, processing, and wait lists for eligible veterans.

(3) Assigning a VISN ACA leadership team (Quadrad).

(4) Assigning a VISN ACA Point of Contact (POC).

(5) Ensuring the VISN ACA Steering Committee includes at least the VISN Quadrad, the VISN ACA POC, and a VISN Office ACA sponsor. **NOTE:** *A sponsor is an executive or senior management level official, within the VISN, assigned authority by the VISN Director for oversight of the ACA program within the VISN. The ACA POC is the VISN ACA project coordinator assigned by the VISN Director and responsible for, among other things, liaison between the VISN, field facilities, and VHA Central Office.*

b. **Facility Director.** The facility Director, or designee, is responsible for ensuring:

(1) That the principles and strategies of the ACA initiative are implemented in all clinics.

NOTE: Additional information on ACA may be found at the following web site:

<http://aca.vssc.med.va.gov>

(2) The balancing of supply and demand for Outpatient Services is accomplished through continuous forecasting and contingency planning. Facilities need to continuously monitor current and future demand for outpatient care in all modalities at all locations (at all campuses and CBOCs of the facility), forecast instances in which demand can be expected to exceed capacity on either a permanent or temporary basis, and be prepared in advance to immediately augment capacity at any location affected through appropriate actions to include but not limited to adding new PC panel(s) and/or specialty care staffing. For example: if feasible, facilities need to anticipate clinical staff departures and identify, in advance of the clinician's departure, some other clinician within the VISN to be detailed to provide coverage to avoid any interruption of services or the closing of clinics.

(3) That a Facility Point of Contact for ACA and a PCMM Coordinator are assigned, and that effective coverage is available for any absences or vacancies.

(4) The creation and maintenance of a master list of all staff who have any of the VistA Scheduling options that may be used for scheduling patient appointments in response to requests received, PCMM menu options for primary care team and/or provider assignments, and menu options for entries onto the EWL.

(5) That all clinic profiles have been reviewed for accuracy, are appropriately utilized, and are reviewed on an annual basis.

(6) Written certification is provided annually, and is sent through the VISN Director to the Deputy Under Secretary for Operations and Management (10N). **NOTE:** *The first written certification is due March 1, 2007.*

5. REFERENCES

- a. Pub. L. 104-262.
- b. Title 38 United States Code (U.S.C.) Sections 1710 and 1705.
- c. Code of Federal Regulations, § 17.100, 17.36, 17.37, 17.38, and 17.49.

6. FOLLOW-UP RESPONSIBILITY: The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for the contents of this Directive. Questions may be directed to the Clinical Quality Assurance Liaison at 202-273-5852.

VHA DIRECTIVE 2006-055
October 11, 2006

7. RESCISSIONS: None. This VHA Directive expires October 31, 2011.

Michael J. Kussman, MD, MS, MACP
Acting Under Secretary for Health

DISTRIBUTION: CO: E-mailed 10/12/06
FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 10/12/06

ATTACHMENT A

GENERAL BUSINESS RULES

1. No service or facility can use informal scheduling systems to give patient appointments. All outpatient clinic appointments must be scheduled using Veterans Health Information Systems and Technology Architecture (VistA) Scheduling options (including appointments made for clinic visits, consultations, medical, surgical, dental, psychiatric, home care, and diagnostic procedures).

a. The only exception to this rule is for outpatient appointments for surgical or oral (dental) surgical procedures to be done in an Operating Room (OR), which are scheduled using the surgical package software.

b. The reason for this exception is that the surgical software package provides functionality that is not available in the VistA Scheduling software.

c. This exception is not meant to preclude the practice of using both the VistA Scheduling software and the surgical OR software simultaneously. The Dental software package has no scheduling functionality. Therefore, the only dental exception to appointment entry into VistA Scheduling software is for outpatient oral (dental) surgical procedures performed in the OR, which are entered in the surgical OR software application. All other outpatient dental appointments must be scheduled using VistA Scheduling options.

2. Access to the VistA Scheduling options for scheduling appointments, Primary Care Management Module (PCMM) menu options for assigning patients to provider and/or team panels, and options to place patients on the Electronic Wait List (EWL) must be monitored and controlled on a continuous basis to assure staff competency to perform these duties.

3. Veterans Health Administration (VHA) providers must use the Computerized Patient Record System (CPRS) consult software (i.e., the consult tab in CPRS) to generate all requests for specialty care consultation.

4. The only approved electronic wait list is the VistA EWL. No other wait lists can be used for clinical services.

5. No service or facility is to “hold” consults or procedure requests, or make use of informal wait lists for any outpatient service, including but not limited to requests for consultations or outpatient procedures (dental, gastrointestinal (GI) endoscopy, cardiac catheterization, etc.).

6. All patients must be scheduled for care using the following business rules:

a. **Urgent or Emergent Care**

(1) Patients with emergent or urgent medical needs must be provided care, or be scheduled to receive care as soon as practicable, independent of service-connected (SC)

VHA DIRECTIVE 2006-055

October 11, 2006

status and whether care is purchased or provided directly by the Department of Veterans Affairs (VA). This does not include patients who use the emergency room or urgent care settings simply for routine renewal of medication or patients seeking VA prescriptions for medications that have been prescribed by outside providers.

(2) A wait list for hospice or palliative care must not be maintained. VHA must offer to provide or purchase needed hospice or palliative care services without delay. **NOTE:** *It is the responsibility of each facility to implement a system whereby patients with urgent needs can be identified, and whereby instructions are given to patients on how to access care for emergent conditions.*

b. Priority Scheduling for Outpatient Medical Services (to include, but not limited to: PC, Medical, Surgical, Behavioral Health, Rehabilitative, and Class 1-V Dental Services, Diagnostic Studies, Geriatric Evaluation and Management, Home-based Primary Care, Purchased Skilled Home Care, Adult Day Health Care, Non-institutional Respite Care, and Homemaker and Home Health Aide Services).

Veterans who are SC 50 percent or greater, or veterans who are rated less than 50 percent requiring care for a SC disability need to be scheduled within 30 days of the desired appointment date specified by the patient or clinician. **NOTE:** *When it is unclear whether the care requested relates to the SC condition, the assumption is to be made that the patient is entitled to priority access. For cases that are unclear, the administrative staff is encouraged to consult with the PCP or member of the clinical team. In the event a veteran disagrees with an administrative decision, the decision may be referred for clinical review and determination.*

ATTACHMENT B

**BUSINESS RULES TO ENSURE COMPETENCY
OF STAFF INVOLVED DIRECTLY OR INDIRECTLY IN THE OUTPATIENT
SCHEDULING PROCESS**

1. At each facility a current master list must be created and maintained to include:
 - a. The individual names of all staff involved directly or indirectly in the outpatient scheduling process; and
 - b. The direct supervisors of such individuals who have access to the menu options for the scheduling of outpatient services, including clinic visits, consultations, Primary Care Management Module (PCMM) primary care team and/or provider assignments, and entries into the Electronic Wait List (EWL).
2. Each staff involved directly or indirectly in the outpatient scheduling process, and the staff's supervisor must:
 - a. View the video either directly or on the web site at:
<http://vaww.sites.lrn.va.gov/VistAschedule/VistAschedulingtips.html>, "Veterans Health Information Systems and Technology Architecture (VistA) Scheduling Software: Making a Difference." This training must be documented within the facility's employee education program (Training Education Management Program Office (TEMPO) or other acceptable process tracking employee education).
 - b. Have successfully completed the Veterans Health Administration (VHA) Comprehensive Scheduler's Training Program. This training must be documented within the facility's employee education program (TEMPO at most locations).
 - c. Have their position description or functional statement include specific responsibilities relative to scheduling, PCMM assignments, and entries into EWL.
 - d. Have on file with their supervisor an annual competency assessment that is inclusive of their responsibilities relative to scheduling, PCMM assignments, and entries into EWL.
 - e. Be monitored, on an on-going, continuous basis using local facility and/or Veterans Integrated Service Network (VISN)-approved processes and procedures, in terms of their performance in scheduling, PCMM assignments, and entries into EWL.
 - f. Be subject to annual performance reviews relative to their responsibilities for scheduling, PCMM panel assignments, and entries into EWL.
3. No individual is to be granted access to these menu options until the requirements in preceding paragraph 2 have been satisfied for both the individual and their direct supervisor.

VHA DIRECTIVE 2006-055

October 11, 2006

4. When VHA Scheduler Refresher Training programs are announced, the facility Director must ensure documentation of successful completion within 60 days by all individuals with access to these menu options and their direct supervisors.
5. Failure to comply with these business rules may be justification for loss of scheduling, PCMM, and EWL menu options.
6. All individuals involved in the scheduling and reception process must be properly trained, supported, and monitored in order to ensure:
 - a. Responsiveness and courtesy to patients, whether in person or when calling in by phone;
 - b. Patient satisfaction; and
 - c. Provider satisfaction.
7. Clinic profiles must be reviewed annually, at least, for accuracy to ensure:
 - a. Each clinic schedule reflects the true availability of that clinic;
 - b. Scheduling instructions are included within each profile to ensure correct scheduling into that clinic by schedulers; and
 - c. Each clinic profile includes scheduling instructions for overbook capacity.

October 11, 2006

ATTACHMENT C

BUSINESS RULES FOR ENROLLMENT AND REGISTRATION

1. All initial applications for care and/or enrollment are to be processed by the receiving Veterans Health Affairs (VHA) facility as soon as administratively feasible, but no later than 7 calendar days of receipt of a signed application from a veteran.
2. When an enrolled veteran requests care at a new site, intake personnel are to use REGISTER ONCE functionality. This is invoked by using the option "Register a Patient" to enter the veteran's basic identifying information into Veterans Health Information Systems and Technology Architecture (VistA) (at a minimum this must include the veteran's full name, Social Security Number (SSN), date of birth, and gender). Once these data are entered, a query is sent to the Master Patient Index (MPI). A query is also sent to the Health Eligibility Center (HEC) for verified eligibility and enrollment information. Assuming the veteran is enrolled, the MPI returns core identity information and HEC returns verified eligibility and enrollment information that is automatically uploaded into VistA. The veteran's demographic information from the Last Site Treated (LST) is retrieved and automatically loaded into VistA, filling in the remaining Registration questions. **NOTE:** *Training material and documentation for the Register Once functionality is available on VistA U at:*
<http://vaww.vistau.med.va.gov/vistau/Enrollment/Archive/RegisterOnce.htm>
3. Generally, enrolled veterans whose eligibility status has been verified need not be asked to provide proof of military service.
4. If, after a review of the registration information, a question about eligibility arises, the last resort is to request the veteran to provide proof of eligibility. **NOTE:** *VA staff have a duty to assist the veteran with obtaining verification of eligibility using all resources available.* Facility staff must query existing Department of Veterans Affairs (VA) sources which include;
 - a. The referring VHA facility;
 - b. Any other VHA facility that has treated the veteran;
 - c. Veterans Benefits Administration (VBA) via VistA's Hospital Inquiry (HINQ), or the Intranet BDN/BIRLS Access (IBBA);
 - d. VBA by phone or through submission of a VAF 10-7131, Exchange of Beneficiary Information and Request for Administrative and Adjudicative Action; or
 - e. The Veterans Information Solution (VIS), etc.
5. If eligibility cannot be verified through the preceding sources, staff are to complete registering the patient with an eligibility status of Pending Verification. VHA staff must:

VHA DIRECTIVE 2006-055

October 11, 2006

a. Coordinate with the Records Processing Center (RPC) or Regional Office (RO) to obtain verified information and/or documentation.

b. Assist the veteran with obtaining proof of active duty military service by providing a hard copy of SF-180, Request Pertaining to Military Records, or through referral to <http://vetrecs.archives.gov>.

6. When a newly-enrolled or newly-registered patient requests clinical care, scheduling needs to be completed when the request is received (same day). If this cannot be accomplished, the enrollment, registration, or other assigned scheduling staff must immediately (same day request received) enter the patient's name on the Electronic Wait List (EWL) for the clinic and preferred location requested, indicating "newly enrolled or newly registered patient pending scheduling" in the comment section of the EWL. **NOTE:** *Veterans with Urgent/Emergent needs are not to be placed on the EWL.*

ATTACHMENT D

BUSINESS RULES FOR SCHEDULING

1. Veterans who are service connected (SC) 50 percent or greater (Class I-V for dental patients) need to be scheduled to be seen for the service requested within 30 days of the desired date for any condition.
2. Veterans who are rated less than 50 percent SC requiring care for a SC disability, need to be scheduled to be seen for the service requested within 30 days of the desired date. When in doubt as to whether the request for care is for the SC disability, Veterans Health Administration (VHA) staff are to assume, on behalf of the veteran, that the veteran is entitled to priority access and schedule within 30 days of desired date.
3. All other veterans need to be scheduled to be seen within 120 days of the desired date.
4. All outpatient appointment requests must be acted on as soon as possible, but no later than 7 calendar days from the date of the request.
 - a. This includes requests from newly-enrolled or newly-registered patients to the facility. As these patients may be entered on the Electronic Wait List (EWL) pending assignment in Primary Care Management Module (PCMM) to the panel of a Primary Care Provider (PCP) or team, PCMM Coordinators will check the EWL daily and act on requests received. Schedulers in all clinics at all locations (substations) must review the EWL daily to determine if a newly-enrolled or newly-registered patient is requesting care in their clinic at their location.
 - b. This includes requests from established patients, consult requests to a specialist, procedure requests, requests for diagnostic studies generated by a VHA physician, requests for dental care, outpatient geriatric evaluation and management, home-based primary care, purchased skilled home care, adult day health care, non-institutional respite care, and homemaker and home health aide services.
5. The requirement to act on a request as soon as possible, but no later than 7 calendar days from the date of the request may be fulfilled by any of the following actions by the receiving service:
 - a. Assigning a patient in PCMM to a provider or team, and scheduling an appointment in response to a request.
 - b. Completing the service, consult, procedure, or study;
 - c. Discontinuing the consult, procedure, or study; or
 - d. Canceling the consult, procedure, or study.

VHA DIRECTIVE 2006-055

October 11, 2006

6. By the end of the 7th calendar day, if the request has not been fulfilled or an appointment scheduled for the service to be provided within 30 days of the desired appointment date (for patients entitled to priority access as described in pars. 1 and 2) or 120 days of the desired appointment date for all others, the patient must be immediately placed on the EWL. If unable to schedule within 7 calendar days, any newly-enrolled or newly-registered patient previously entered on the EWL pending scheduling must remain on the EWL with appropriate revision of the comment section.
7. When placing the patient with SC priority on the EWL, it must be documented in the comment section of the EWL that care cannot be provided within 30 days.
8. Designated staff are expected to carefully monitor those SC veterans entitled to priority scheduling entered on the EWL, and make every effort to have them seen as soon as possible.
9. Priority scheduling of any SC veteran is not to impact the medical care of any other previously-scheduled veteran. Veterans with SC disabilities are not to be prioritized over other veterans with more acute health care needs.
10. When the patient is to be seen in multiple clinics, every effort is to be made to assist the patient in coordinating appointments to enable the veteran to make a minimum number of visits to the treating facility. To the extent possible and as medically indicated, relevant diagnostic testing needs to be done in advance of the referral visit.
11. Sufficient overbook capacity is permitted to avoid the necessity for recording “unscheduled” visits when patients are seen on a “walk-in” basis.
12. Areas where overbook capacity is frequently depleted are to be reviewed. Clinic structures in these locations need to be evaluated and adjusted to allow appropriate credit to the clinic for performing today's work today.
13. When an appointment is scheduled in response to a consult, there needs to be a comment entered into the “Other Info” section of the Veterans Health Information Systems and Technology Architecture (VistA) Scheduling software to that effect.
14. When the requested date by the patient is not consistent with the date given by the provider as the “desired date,” a comment needs to be entered in the “Other Info” section explaining the patient requested the appointment date.
15. Within the VistA Scheduling software, when an appointment is scheduled as a “Next Available” appointment, the “desired date” defaults to the date the appointment is created. Desired date is appropriately the date the appointment is created when:
 - a. The patient asks to see the clinician as soon as possible or any indication thereof.
 - b. The clinician requests the patient be scheduled for the Next Available Appointment, first available, "as soon as possible," or "overbook or next clinic," or any indication thereof.

c. Scheduling a walk-in patient, who is to be seen same day by the provider. If the provider's schedule is full, but there is still overbook capacity, the appointment must be scheduled using the overbook slot.

16. A consult to a specialty clinic is considered a request to be seen as soon as possible, unless there is clear documentation by the requesting provider that the requested appointment date is not 'as soon as possible' (for example, if there is documentation this is a request for the service to be provided in 3 months) or unless the patient specifically requests a later appointment (this too needs to be documented).

17. When entering a Not-Next Available appointment, the scheduler is asked to enter a specific "desired date." The "desired date" entered is to be the date specified by the clinician or by the patient.

18. If an appointment is not available at the time originally specified by the clinician, but the clinician accepts and documents that a later appointment is acceptable, that later appointment date is to be entered as the "desired date."

19. However if the date requested by the patient is not available, and the patient agrees to another appointment that is later, due to lack of availability when the appointment was wanted, the "desired date" is still to be entered as the date the veteran originally requested.

20. Schedulers need to utilize the "Other info" to document any scheduling changes, such as changes of "desired date."

21. Providers need to avoid using a date range, or if using, need to indicate a date range not greater than 30 days. When a clinician provides only a date range for the "desired date" like "sometime next month" or "between 4 and 5 months in the future," the "desired date" entered needs to be the first day of the date range for which the appointment is being requested. In cases of doubt, schedulers are to clarify with the clinician.

22. Recall, reminder systems, or other forms of patient-driven scheduling may be used in the scheduling of follow-up appointments, but facilities must ensure that the patient entitled to priority access is given an appointment date within 30 days, and 0-120 days for all others of the desired appointment date. If the appointment date cannot be scheduled within these timeframes, the patient is to be placed on the EWL.

23. When recall, reminder systems, or other types of patient-driven scheduling options are used for follow-up appointments, the facility retains principal responsibility for providing the patient an appointment to be seen within the appropriate timeframes (see preceding par 21).

24. When using a recall or reminder system, if the patient calls in at the specified time requesting an appointment, and no appointment is available within these timelines, the patient must not be asked to call back. The patient must be placed on the EWL with that original desired date indicated and contacted when an appointment becomes available.

VHA DIRECTIVE 2006-055

October 11, 2006

25. If the patient fails to call in, the facility retains responsibility to call and/or send a reminder letter and to make available a scheduled appointment for the patient to be seen within 120 days (30 days for patients entitled to priority access) of the originally specified desired date.

26. Failure to contact the patient after a second attempt must be documented and a notice generated to the provider for a decision on further action.

ATTACHMENT E

BUSINESS RULES FOR CONSULT MANAGEMENT

1. The consult service at each facility must set up internal processes to triage incoming consults.
2. All requests and/or referrals for consultative services must be initiated in the Computerized Patient Record System (CPRS) using an electronic consult request.
3. All services must make use of the menu options within the Veterans Health Information Systems and Technology Architecture (VistA) Scheduling software to schedule outpatient clinic appointments in response to consult requests, with the exception of appointments scheduled using the surgical software Operating Room (OR) applications. *NOTE: Until such time as software is in place to accomplish this automatically, the scheduler must manually enter under "Other Info" the comment that the appointment is scheduled in response to consult and include the consult number plus the date of the request.*
4. All STAT (immediate) and urgent consults for patients on inpatient status must be completed prior to discharge.
5. In instances in which a patient is ready for discharge prior to completion of a routine inpatient consult, the patient needs to be discharged and the consult converted to an outpatient consult (providing the facility differentiates between inpatient and outpatient consults). The receiving specialty service continues to be responsible for completing that consult on an outpatient basis.
6. A system must be in place at each facility to notify providers that a "STAT," "emergency," or "urgent" outpatient consult has been requested from their specialty or subspecialty service. Effectiveness of this notification system is to be monitored. If the system is not functional or not answered, back-up systems need to be developed and used at the facility to ensure notification to the specialty provider of these types of consults.
7. "Emergency" intra-facility and inter-facility consultation services are to be negotiated between the requesting and receiving facility physicians, and responded to as quickly as possible, and as deemed appropriate, commensurate with the level of urgency and/or patient transport and transfer requirements.
8. "Urgent" outpatient consults are to be seen by the specialty or subspecialty service, and a consult report signed and available to the requesting party within 24 hours, but no longer than 72 hours of consult request.
9. "Routine" outpatient intra-facility and inter-facility requests for consultations are to be acted on by the specialty or subspecialty service as soon as possible, but no later than 7 calendar days of the request. To act on the consult is to complete or deny the consult, schedule an appointment for the patient to be seen within timelines required (0-30 days for patients entitled to priority access and 120 days for others), or place the patient on the

VHA DIRECTIVE 2006-055

October 11, 2006

Electronic Wait List (EWL). The receiving service is responsible for acting on the consult and for supporting documentation of actions taken. The requesting provider is to be alerted to these actions.

10. The receiving service must change the status of consults received, as soon as possible, but no later than 7 calendar days of the request receipt, to reflect the action taken as to:

- a. **Schedule.** This marks a consult as being scheduled. An alert is sent to the requesting provider.
- b. **Cancel (Deny).** This is used by receiving service to cancel or deny consult. An alert is sent to the requesting provider.
- c. **Edit/Resubmit.** This is used by the requesting provider to resubmit a canceled consult. An alert is sent to the requested service.
- d. **Discontinue.** This is used by the ordering provider to discontinue a consult no longer wanted or needed. An alert may be sent to the requested service, depending on the service setup.
- e. **Forward.** This is used by the receiving service to forward to another service for action if sent to the wrong service. This is not used to forward to a specific provider. An alert is sent to the requesting provider.
- f. **Add Comments.** This is used to document activity taken while processing a consult. An alert is sent to the requesting provider. This may include a question back to the ordering provider, who will need to “Add Comment” again, and must be sure to include the original commenter as an alert recipient by checking “Send addition” alert.
- g. **Significant Findings.** This allows a clinic or service to append a “significant findings flag” onto a consult (whether completed or not). An alert is sent to the requesting provider.
- h. **Administrative Complete.** This completes a consult without a consult titled progress note, which is usually completed by a clerk. An alert is sent to the requesting provider.

11. When subsequent actions are taken that should trigger a status change, the receiving service is responsible for documentation as needed of reasons for their choice of action (for example, when canceling or denying), and for making those status changes, consistent with the action taken (until an electronic action that automates any such changes is available). Status of consults include the following:

- a. **Complete (c).** The service has been performed. This requires no further action by the ancillary service.

- b. **Cancel/Deny (x)**. The request has been rejected by the ancillary service without being acted on. The consult receiver uses the “Cancel/Deny” action.
- c. **Discontinue (dc)**. The request has been stopped prior to expiration or completion. The consult originator uses the “Discontinue” order action.
- d. **Pending (p)**. The requests that have been placed, but not yet accepted, by the service filling the order.
- e. **Partial Result (pr)**. All or part of a consult completion report has been entered, but has not yet been signed, by an attending provider.
- f. **Scheduled (s)**. The receiving clinic has scheduled an appointment for the patient.

12. The comments on details about No Shows or Cancellations need to be entered under “Other Info” in VistA Scheduling software package, and under “comments” on the consult. Comments are to include information that may have been provided by the patient, if the patient called in to cancel. If a cancelled appointment has been rescheduled; that information needs to be included in the comments.

13. Written clinic-specific policies must be established for the management of no-shows in response to scheduled appointments, based on consult or procedure requests. At a minimum, these policies must ensure that after a specified number of no-shows, the consult request will be canceled and a notification sent to the ordering provider who then is responsible for determining the next appropriate action.

14. The requesting provider, or designee, must contact the patient to:

- a. Determine the reason for a patient no show;
- b. Assist the patient in rescheduling a new appointment acceptable to the patient.

NOTE: *It may be useful for a case manager to be assigned to the patient with multiple no-shows to determine the best method to deal with the patient’s pattern of repetitive no-shows.*

15. No duplicate requests for consultation (with the exception of the required notification phone calls for “STAT,” “urgent,” and “emergency” consultations) are to be issued.

16. Provisions for electronic inter-facility consults are to be properly set up in advance for any required specialty or subspecialty consultation services. This requires fields being completed to:

- a. Designate the type of consultation requested; and
- b. Indicate which facility is the "requesting" site and which is "consulting" site.

VHA DIRECTIVE 2006-055

October 11, 2006

17. The facility receiving the consultation must electronically "complete" the consult with an appropriately-labeled consult note (this must be done using the Consult tab of CPRS) so the provider at the requesting facility sees that consult note as a document related to the consult. **NOTE:** *The requesting site must do a "results display" on the inter-facility consult from the Consults tab in CPRS. The consult status changes from "p" to "c" and is visible at each site.*

ATTACHMENT F

BUSINESS RULES FOR USE OF THE VISTA ELECTRONIC WAIT LIST (EWL)

1. The Veterans Health Information Systems and Technology Architecture (VistA) Electronic Wait List (EWL) software must be used by facilities to capture and track information about patients waiting for Primary Care (PC) provider and/or team assignments in the Primary Care Management Module (PCMM) and outpatient clinical services. This applies to appointments for all outpatient services and outpatient procedures. Outpatient services include medical, surgical, dental, and other procedures done on an outpatient basis in or out of the Operating Room (OR), as well as appointments for primary care, medical, surgical, behavioral health, rehabilitative, and dental services; diagnostic studies; outpatient geriatric evaluation and management; Home-based Primary Care; purchased skilled home care; adult day health care; non-institutional respite care; and homemaker and home health aide services.

2. The EWL must be used when patients not eligible for priority access cannot be scheduled for the service requested within 120 days of the desired appointment date. For patients not seen within 24 months by that service at that facility, the assumption is that the “desired date” is the date the request was submitted, unless otherwise specified by the patient or requesting provider.

3. The EWL must be used when service connected (SC) patients eligible for priority access cannot be scheduled to be seen within 30 days of the desired appointment date. For patients not seen within 24 months by that service at that facility, the assumption is that the “desired date” is the date the request was submitted unless otherwise specified by the patient or requesting provider.

4. **Veterans Transfer of Care**

a. When a veteran who has been receiving ongoing care at a Department of Veterans Affairs (VA) facility permanently changes the place of residence, the veteran needs to be provided treatment based on an established provider-patient relationship. **NOTE:** *VA has an obligation to ensure that it continues the care of these patients.*

b. Established patients wishing to transfer care to a more convenient location, but for whom VA care is currently accessible (e.g., transfer care from one campus or Community-based Outpatient Clinic (CBOC) within a VA facility to a closer Campus or CBOC), may be subject to being placed on the EWL, and flagged as transfer patients until the service requested becomes available at their desired location. Until the EWL software has the capability to flag transfer patients, these patients need to be placed on the EWL in non-count clinics with the primary Decision Support System (DSS) Identifier 674 plus a locally defined DSS stop code in the credit position. Veterans Health Information Systems and Technology Architecture (VistA) non-count clinic transfer patients should not be included in DSS data.

VHA DIRECTIVE 2006-055

October 11, 2006

5. **Use of Wait Lists When PC Panels are Full at a Preferred Location.** If a patient would like to receive ongoing PC and the panels at the preferred location are at capacity, the patient is to be placed on the EWL for panel placement.

a. If there is availability on a PC panel at another proximate VA location, the patient needs to be offered this as an alternative care site on an interim basis. If the patient refuses to accept PC at the alternate location, the patient needs to be placed on the EWL for the location where PC is desired, and a note must be entered in the comments section of the EWL that the patient refused PC at the alternate location.

b. If the patient accepts an appointment at the alternative site, the patient is to still be placed on the EWL to receive PC at the preferred location, designated as a transfer patient in the EWL software, and informed when a panel slot becomes available at their desired location. . Until the EWL software has the capability to flag transfer patients, these patients need to be placed on the EWL in non-count clinics with the primary DSS Identifier 674 plus a locally defined DSS stop code in the credit position. VistA non-count clinic transfer patients should not be included in DSS data.

6. **Use of Wait Lists.** When wait times exceed 120 Days (or exceed 30 days for patients entitled to Priority Access) for Specialty Care Services at a CBOC or at a Campus of an integrated Health Care System (HCS), the following apply:

a. If a patient would like to receive specialty care from an established specialty clinic at a CBOC, or at one specific campus of an integrated HCS, but cannot be scheduled to be seen within 0-120 (or 0-30 days for patients entitled to priority access) at that location, but could be scheduled within these time frames at another location within the facility, the patient is to be offered an appointment at that other location on at least an interim basis.

b. If the patient refuses to accept specialty care at the alternate location, the patient needs to be placed on EWL for the location and specialty desired and a note entered into the comments section of the EWL that the patient refused specialty care at the alternate location.

c. If the patient accepts an appointment at the alternative site, the patient is still to be placed on the EWL to receive specialty care at the preferred location, designated as a transfer patient in the EWL software, and informed when a timely appointment becomes available at their desired location.

d. Until the EWL software has the capability to flag transfer patients, these patients need to be placed on the EWL in non-count clinics with the primary DSS Identifier 674 plus a locally defined DSS stop code in the credit position. VistA non-count clinic transfer patients should not be included in DSS data. ***NOTE: The patient is to be removed from EWL if their specialty care need is completed at the alternate location.***

7. **Use of EWL.** When wait times for outpatient services exceed 120 Days (or exceed 30 days for patients entitled to Priority Access) for Home-based Primary Care, purchased skilled Home Care, Adult Day Health Care, Non-institutional Respite Care, Homemaker

and Home Health Aide Services, or outpatient Geriatric Evaluation and Management, and when in spite of all efforts to balance supply and demand, through forecasting and contingency planning and use of other Advanced Clinical access (ACA) principles, there is no capacity to provide the outpatient service requested within the mentioned timelines, the patient must be placed on the EWL, and a note entered in the EWL to clearly document that the patient is waiting for the specific service at a preferred location or in a town or county or other location for which capacity is currently unavailable.

8. Use of the EWL for Outpatient Services to be Performed in the Operating Room (OR)

a. The EWL is to be used for those patients who have been identified as needing an outpatient procedure, but the procedure cannot be scheduled within required timelines (0-30 days from desired date for patients entitled to priority access, 0-120 days for all others) due to the lack of availability of operating rooms or other resources.

b. The patient needs to remain on the EWL until such time that an actual surgery is performed.

9. Veterans are to be Notified of their Placement on the EWL. This notification must be documented and needs to specify that the veteran has been notified in person or by phone, of the following:

- a. VA is not able to provide care within the time period desired by the patient;
- b. The approximate expected waiting time;
- c. Instruction on what to do in case of an emergency; and
- d. That the patient will be contacted when appointment slots become available.

10. The facility Director, or designee, is responsible for having appropriate mechanisms in place to monitor the:

- a. Time in queue for patients awaiting their first appointment for PC;
- b. Time in queue for patients awaiting their first specialty care appointment;
- c. Number of patients on EWL for a PC panel assignment, or a PC appointment; and
- d. Number of patients on EWL for specialty care by specialty.

11. If the condition of any patient on the EWL becomes urgent or emergent, as determined locally, this patient must:

- a. Take precedence over all other patients;

VHA DIRECTIVE 2006-055

October 11, 2006

- b. Be provided appropriate care and follow-up and removed from the EWL.
12. Any veteran, who is SC 50 percent or greater, or less than 50 percent SC and requiring care for an SC disability, must be given priority when removing patients from the EWL.
13. When removing or considering putting patients on the EWL, veterans who have been receiving ongoing care at another VA facility and who have permanently changed their place of residence must be treated as if they have an established patient-provider relationship at the facility.
14. All other patients need to be removed from the EWL on a first-on, first-off basis.
15. Patients need to be removed from a facility's EWL when any of the following conditions occur:
- a. The patient is no longer seeking care from that VA facility (e.g., the patient has moved, declined care at that site, or died), or is no longer eligible for care..
 - b. The patient has been seen for the requested care, or is scheduled an appointment within 30 days (patient entitled to priority access) or 120 days (all others) in the requested clinic.
 - c. The facility has not been able to contact the patient to schedule an appointment. Attempts to contact the patient must include at least three phone calls at least 5 days apart plus a letter to the patient. These actions are to be documented in an administrative note in the Computerized Patient Record System (CPRS).
16. When canceling an appointment at the request of a patient, the user (e.g., scheduling clerk) sees a message on the screen indicating if there are patients on the EWL for that clinic or service specialty. This message should prompt the schedule to make use of this patient cancellation to schedule a patient waiting on the EWL to be seen.
17. Clinics requiring EWL are to be closely monitored for canceled appointment slots.
18. Veterans with urgent and/or emergent needs are not to be placed on the EWL.
19. Patients are to be removed from the primary care panel EWL, when they are assigned to a primary care panel at the preferred location.
20. Patients are not automatically removed from the clinic appointment EWL. Instead, when an appointment is scheduled in a clinic for which the patient has been on the EWL, the user (e.g., scheduling clerk) will be asked if they want to remove (inactivate) the patient from the EWL. If the user answers "no," the patient must remain on the EWL with the appropriate reason entered in the "Do Not Remove Reason" field as to why the entry has not been closed.

21. The EWL must be closely managed by the facility Director or designee. ***NOTE:*** *It is recommended that the list is reviewed weekly to disposition patients in a timely manner.*

ATTACHMENT G

**BUSINESS RULES FOR HANDLING NO-SHOWS,
PATIENT CANCELLATIONS AND CLINIC CANCELLATIONS**

1. When the patient calls or sends advance notice to a Department of Veterans Affairs (VA) employee that the patient cannot appear for a scheduled appointment, it is the responsibility of that VA employee to immediately notify the appropriate administrative support staff to ensure the appointment is correctly coded as canceled by patient.
2. When a patient does not report (no-show) for a scheduled appointment, the responsible provider, surrogate, or designated team representative is to review the patient's medical record, including any consult or procedure request received or associated with the appointment; and determine and initiate appropriate follow-up action. ***NOTE:** It may be useful for the facility to assign a case manager to the patient with multiple no-shows to determine the best method to deal with the patient's pattern of repetitive no-shows.*
3. Clinic cancellations, particularly with short notice, are to be avoided whenever possible. Such action may prolong wait times for patient care services, are disruptive to patients and their families, and create additional work for the provider and support staff. Frequent clinic cancellations and appointment rescheduling contribute to patients being lost to follow-up, decreased patient satisfaction, and increased numbers of no-shows.
4. If, after all alternatives have been considered, a clinic must be canceled, the responsible provider, surrogate, or designated team representative is to review the records of the scheduled patients, ensure that urgent medical problems are addressed in a timely fashion, ensure that provisions are made for necessary medication renewals, and ensure that patients are rescheduled to be seen on a clinically-appropriate basis.
5. Elective clinic cancellations are those canceled for the convenience of the provider or the local VA facility; for example:
 - a. The clinic appointment is canceled because of the planned annual leave, sick leave, or authorized absence of the health care provider.
 - b. The clinic appointment is canceled because of the departure or reassignment of the health care provider, this includes the reassignment of the patient to a new health care provider.
 - c. The clinic appointment is canceled because of the revision of clinic profiles resulting in rescheduling of patients to be seen in another clinic under a new clinic profile.
 - d. The clinic appointment is canceled because it was erroneously entered into the wrong clinic.
6. Requests to cancel a clinic must be submitted in writing within time frames specified in local facility or Veterans Integrated Service Network (VISN) policy accompanied by: an

VHA DIRECTIVE 2006-055

October 11, 2006

appropriate justification, provisions made to ensure effective implementation of a patient notification, and a rescheduling plan.

7. Prior to electively canceling the clinic, all alternatives must be considered in order to secure provider coverage, or otherwise manage the affected patients.
8. Procedures must be in place at all facilities for the management of non-elective clinic cancellations (canceled because of unforeseeable circumstances such as provider illness or unplanned emergency leave, weather emergencies, etc.) including procedures for patient notification, surrogate coverage when possible and appropriate, and/or timely rescheduling.
9. Canceling clinics for an entire day is to be avoided as this approach does not permit the entry of comments. The preferred method is to cancel in specified time frames which will permit the entry of comments.